COMMUNITY 2026 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Gold

PLANS/VISITS	PREMIER GOLD 005 PLAN ID 27248TX0010005	PREMIER GOLD 021 PLAN ID 27248TX0010021	SELECT GOLD 022 PLAN ID 27248TX0010022
Medical Deductible (individual/Family)	$2,500/$5,000	$2,000/$4,000	$2,000/$4,000
Out-of-Pocket Max (individual/Family)	$7,500/$15,000	$8,200/$16,400	$9,200 / $18,400
MEDICAL BENEFITS			
PCP Office Visit	*$20	*$30	*$15
Specialist Office Visit	*$40	*$60	*$30
Outpatient Facility	25%	25%	30%
Outpatient Surgery	25%	25%	30%
Urgent Care Services	*$40	*$45	*$30
Ambulance Services	$40	$60	$30
Emergency Room Services	25%	25%	30%
Inpatient Hospital Care	25%	25%	30%
Inpatient Skilled Nursing Facility	25%	25%	30%
Outpatient Mental/Behavioral Substance Abuse	*$20	*$30	*$15
Inpatient Mental/Behavioral Substance Abuse	25%	25%	30%
Outpatient Rehabilitation	$40	*$30	$30
Medical Imaging (CT/PET Scans, MRIs)	25%	25%	30%
Routine Lab/X-Ray/Diagnostic Imaging	$20	25%	$15
PRESCRIPTION DRUGS			
Prescription Drug Deductible (individual/Family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$10	*$15	*$10
Preferred Brand	$50	*$30	*$50
Non-Preferred Brand	$75	*$60	$100
Specialty High-Cost Drugs	35%	*$250	40%

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX).
For deductible plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.